

NOTE: THIS SECTION IS STILL SUBJECT TO CHIP PROGRAM STAFF

REVIEW AND MAY BE REVISED -- ANY REVISIONS WILL BE POSTED BY COB 12/8/99

Article 1. SCOPE OF CHIP BENEFITS

Section 1.01 Basic required benefits.

The CONTRACTOR is paid capitation for all services listed in the Summary of HMO Benefits included in Appendix __ to this Agreement. **NOTE: This is Appendix C, as amended, to the RFP.** Unless Appendix _ specifies otherwise, the CONTRACTOR may determine if a benefit requires prior authorization, pre-certification, or physician prescription. The CONTRACTOR must pay for or reimburse for all CHIP-covered services provided to enrollees for whom the CONTRACTOR is paid capitation.

Out-of-network and emergency services also must be provided in accordance with the Texas Insurance Code and TDI regulations as they apply to HMOs. Covered services are subject to change due to changes in federal law, changes in CHIP policy, and/or responses to changes in medicine, clinical protocols, or technology. If covered services change, the change will be the subject of a change order as provided in Article __ of this Agreement.

Section 1.02 Value-added benefits. {Only for those HMOs that are offering these benefits}

The CONTRACTOR must also arrange for the provision of the following value-added services, offered by the CONTRACTOR in its proposal. The CONTRACTOR must provide these value-added services at no additional cost to HHSC. The CONTRACTOR must not pass on the cost of the value-added services to providers. The CONTRACTOR must specify the conditions and specific parameters regarding the delivery of the value-added services in the CONTRACTOR'S marketing materials and evidence of coverage or member handbook. The CONTRACTOR must clearly state to members any limitations or conditions specific to the value-added services.

If the CONTRACTOR utilizes a prescription drug formulary for CHIP members, the CONTRACTOR must fully disclose its use of the formulary in its marketing materials. During the term of the Agreement, the CONTRACTOR cannot create a new formulary or significantly revise an existing formulary; however, minor revisions to include new drugs or to remove drugs in compliance with FDA directives are allowed. HHSC will determine if a revision is significant. The CONTRACTOR may revise the formulary on an annual basis, subject to HHSC review and approval.

Value-added services can only be added or removed by written amendment of this Agreement. The CONTRACTOR cannot include a value-added service in any material distributed to members or prospective members until this Agreement has been amended to include that value-added service or the CONTRACTOR has received written approval of the suggested value-added service from HHSC pending finalization of the amendment.

If a value-added service is deleted by amendment, the CONTRACTOR must notify each member that the service is no longer available through the CONTRACTOR. The CONTRACTOR must also revise all materials distributed to prospective members to reflect the change in value-added services.

Section 1.03 Dental services.

The CONTRACTOR is not responsible for providing preventive and therapeutic dental services to CHIP members. However, hospital and related medical charges, such as anesthesia, that are associated with dental care, are covered CHIP services. The CONTRACTOR must provide access to facilities and physician services that are medically necessary to support the dentist who is providing CHIP dental services under general anesthesia or intravenous (IV) sedation.

The CONTRACTOR must inform facilities, anesthesiologists, and PCPs what authorization procedures are required, and how providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical emergency services, the CONTRACTOR must reimburse in-network and out-of-network providers in accordance with contractual agreements for covering emergency health conditions.

Section 1.04 Case Management Services for Children with Complex Special Health Care Needs

The CONTRACTOR must have a documented plan for identifying and tracking the services of CHIP-eligible children with complex special health care needs (CCSHCN).

A child, a child's family, a health care provider, the CHIP administrative contractor, or the CONTRACTOR may preliminarily identify a CCSHCN. The CONTRACTOR must confirm the designation of a CCSHCN utilizing the standardized screening instrument provided by the State. Procedures for collecting and processing data for CCSHCN are also being developed; however, the HMO will be required to electronically transmit CCSHCN information to the administrative contractor on a monthly basis.

CCSHCN are eligible for case management services beyond the scope normally provided to other CHIP-eligible children. The CONTRACTOR must provide the following enhanced case management services to CCSHCN as appropriate:

Outreach and Informing - Upon CCSHCN designation, the CONTRACTOR must contact the CCSHCN's family to discuss covered services, including specialty services, the family's right to select a specialist as a primary care provider, out-of-network services applicable to the child's condition, the availability of enhanced care coordination, and community referrals.

Enhanced Care Coordination - CCSHCNs, their families, or their health providers may request enhanced care coordination from the CONTRACTOR. The CONTRACTOR must furnish a care coordinator when requested. The CONTRACTOR may also recommend to the CCSHCN's family that a care coordinator be furnished if the CONTRACTOR determines that care coordination would benefit the child. Care coordinators are responsible for working with CCSHCN, their families, and their health care providers to develop a seamless package of care in which primary, acute, and specialty service needs are met through a single, understandable and rational plan. This written plan must be updated at least annually. The care coordinator will coordinate all services with the PCP and, as necessary, with the child's pediatric specialty care physician. The care coordinator also makes referrals for other community services provided on a value-added basis.

Community Referrals - The CONTRACTOR must make a best effort to implement a systematic process to enlist the involvement of community organizations that may not be providing CHIP-covered services but are otherwise important to the health and well being of CHIP members. The CONTRACTOR also must make a best effort to establish relationships with these community organizations in order to make

referrals for CCSHCN and other children who need community services. These organizations may include, but are not limited to:

Early Childhood Intervention Program (512/424-6745)

Department of Mental Health and Mental Retardation (MHMR) (512/206-4830)

Texas Department of Health (TDH) Title V Program (512/458-7321)

Local School District (Special Education)

Other state and local agencies and programs with jurisdiction over children's services, including food stamps, Women, Infants, and Children's (WIC) Program

Texas Information and Referral Network

Texas Commission for the Blind (TCB)

Child-serving civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, that also work on behalf of the CCSHCN population

Section 1.05 *Pre-existing conditions.*

The CONTRACTOR may not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any CHIP-eligible child.

Section 1.06 *Court-ordered commitments.*

The CONTRACTOR must provide inpatient psychiatric services to members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities.

The CONTRACTOR cannot deny, reduce or controvert the medical necessity of any court-ordered inpatient psychiatric service for members under age 21. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

A member who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code cannot appeal the commitment through the CONTRACTOR'S complaint or appeals process.

The CONTRACTOR must comply with 28 TAC §§ 3.8001, *et seq.* regarding utilization review of chemical dependency treatment.

Section 1.07 *Early Childhood Intervention (ECI).*

(a) *ECI Services.*

The CONTRACTOR must provide all federally mandated services contained at 34 C.F.R. 303.1, et seq., and 25 TAC § 621.21 et seq., relating to identification, referral and delivery of health care services contained in the member's Individual Family Service Plan (IFSP). An IFSP is the written plan which: (1) identifies a member's disability or chronic or complex condition(s) or developmental delay; (2) describes the course of action developed to meet those needs; and (3) identifies the person or persons responsible for each action in the plan. The plan is a mutual agreement of the member's PCP, case manager, and the member/family, and is part of the Member's medical record.

(b) *ECI Providers.*

The CONTRACTOR must contract with qualified providers to provide ECI services to members under age 3 with developmental delays. The CONTRACTOR may contract with local ECI programs or non-ECI providers who meet qualifications for participation by the Texas Interagency Council on Early Childhood Intervention to provide ECI services.

(c) *Identification and Referral.*

The CONTRACTOR must ensure that network providers are educated regarding the identification of members under age 3 who have or are at risk for having disabilities and/or developmental delays. The CONTRACTOR must use written education material developed or approved by the Texas Interagency Council on Early Childhood Intervention. The CONTRACTOR must ensure that all providers refer identified members to ECI service providers within two working days from the day the Member is identified. Eligibility for ECI services is determined by the local ECI program using the criteria contained in 25 TAC §621.21 et seq.

(d) *Intervention.*

The CONTRACTOR must require, through contract provisions, that all medically necessary health and behavioral health care services contained in the member's IFSP are provided to the member in the amount, duration and scope established by the IFSP. Medical necessity for health and behavioral health care services is determined by the interdisciplinary team as approved by the member's PCP. The CONTRACTOR cannot modify the plan of care or alter the amount, duration and scope of services required by the member's IFSP. The CONTRACTOR cannot create unnecessary barriers for the member to obtain IFSP services, including requiring prior authorization for the ECI assessment and insufficient authorization periods for prior authorized services.